DISASTER MENTAL HEALTH
Virginia and Beyond

Edward M. Kantor, M.D.

Assistant Professor of Psychiatric Medicine

Director, Emergency & Community Psychiatry
University of Virginia School of Medicine

Chair, Disaster Committee

Psychiatric Society of Virginia

Director, UVa Medical Reserve Corps

Today's Presentation

3 Parts

1. Overview of Disaster Mental Health
2. Evolving to Evidence-Based Practice
3. Cooperative Community Response

Overview of Disaster Mental Health

Disaster Defined from a Behavioral Perspective

A traumatic event that **overwhelms** a community

A severe disruption (ecological and **psychosocial**) which greatly **exceeds the coping capacities** of that community.

All-Hazards perspective

(Natural- Technological- **Mass Violence**)

Crisis-Disaster Continuum

KEY CONCEPTS OF DISASTER MENTAL HEALTH

- No one who sees a disaster is ***untouched*** by it.
- Most people pull together and function...

  but their ***effectiveness is diminished***.
- Disaster ***stress and grief reactions*** are normal responses to an abnormal situation.
- An **increase** in substance use/abuse and **self-destructive behavior** often accompany disaster situations.

KEY CONCEPTS OF DISASTER BEHAVIORAL HEALTH

- Most people do not feel a need for **mental health** services following disaster and **will not** seek services offered as such.
- Survivors may **reject** disaster assistance of all types.
- True disaster behavioral health assistance is often more **practical** than psychological in nature.
- Disaster behavioral health services must be **tailored** to the communities they serve.

KEY CONCEPTS OF DISASTER BEHAVIORAL HEALTH

- In the early response, set aside traditional methods,
  - -***avoid*** the use of mental health labels
  - -use an ***active outreach*** approach to intervene
- Survivors typically respond to active, genuine interest, and concern.
- Interventions must be ***appropriate to the phase*** of the disaster.
- ***Social support systems*** are crucial to emotional recovery.

Disaster Behavioral Health

≠

Trauma Treatment

Principles of Intervention

First Order Intervention- Peer, Lay, Paraprofessional

- Psychological First Aid- awareness, support, talk
  - -mobilize relevant supports- religious, schools, extended family, etc.…
- Intervention at scene or immediate post event
- (CISM- application controversial
  - Voluntary- available, but not universally applied
  - Separate programs for responders)

Second Order Intervention- Professional, Paraprofessional

- Multimodal Approaches
  - -Supportive, Cognitive, Psychiatric Hosp. for safety issues
  - -Detoxification from substances
  - -Medications- lesser but occasional role

Evidence-Based Practices In Disaster Behavioral Health

Evolving Evidence

Problems associated with scientific study of disaster

- Acute un-planned events
- Emotionally charged aftermath
- Unstable, Changing Physical Environment
- Study regulations/Confidentiality
- Variable Event Types
- Politics
- Lack of interagency cooperation/communication

a body of evidence is evolving even so…

Mental Health and Mass Violence:

Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence

A Workshop to Reach Consensus on Best Practices.

NIH Publication
No. 02-5138, Washington, D.C.: U.S. Government Printing Office.

Epidemiology of Disasters Worldwide: Individuals Affected Annually

50,000 deaths
75,000 serious injuries
200,000 displaced from their homes
8 million affected in some way

Figures derived from International Federation of the Red Cross and Red Crescent Society's (1999) World Disaster Report. Figures represent combined effects of floods, earthquakes, high wind, volcanoes, urban fires, technological accidents.

They do not include effects of drought, famine, or war.

An Empirical Review of the Empirical Literature on the Mental Health Consequences of Disasters, 1981 - 2001

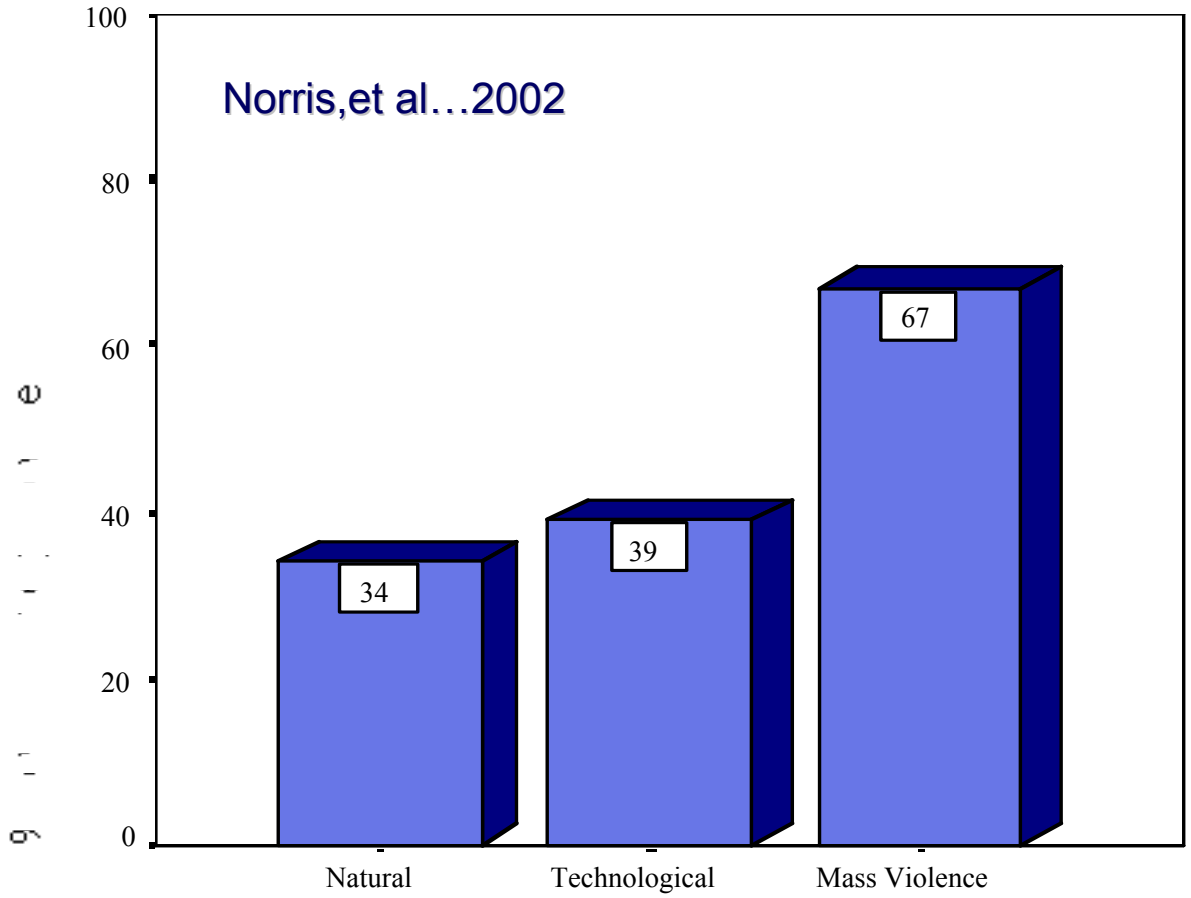
- 250 articles, chapters, and books quantifying effects of *collectively experienced events with sudden onset*.

- They described results for 160 samples and 102 events.

- Looked at the experiential, demographic, and psychosocial factors that influence who within that community is most likely to be adversely affected.

Norris, Friedman, et.al. (2002), Conducted with support from the Center for Mental Health Services (IAA with NCPTSD) NIMH Grant K02 - MH63909 (awarded to F. Norris).

Predicting Overall Severity of Impairment: Effects of Disaster Type



‘At-Risk’ Survivor Characteristics

- Female gender
- Adult survivor, age in the middle years of 40 to 60
- Little previous experience relevant to coping with the disaster
- Membership in an ethnic minority group
- Poverty or low socioeconomic status
- Pre-disaster psychiatric history

North, 1999, Norris 2002

Environmental Factors for Risk

- Severe exposure to the disaster
  - -injury, threat to life and extreme loss

- Living in a neighborhood or community that is highly disrupted or traumatized

- High secondary stress, regardless of whether it is of an acute or chronic nature (multiple hit hypothesis)

Participants in the consensus conference also indicated that early behavioral health assessment and intervention should focus on a hierarchy of needs--

survival, safety, food, shelter, etc.

U.S. vs. Worldwide Impairment

Samples that met criteria for severe impairment post mass violence (in this case bombings)

25% U.S.
48% Other Developed Countries
78% Developing Countries

Highest Risk- School Aged Youths, 62%
Lowest Risk- Rescue and Recovery Workers, 7%

North, et al, 1999

A sensible working principle in the immediate post-incident phase is to expect normal recovery

- Presuming clinically significant disorder in the early post-incident phase is inappropriate, except when there is a preexisting condition.

- Participation of survivors of mass violence in early intervention sessions, whether administered to a group or individually, should be voluntary.

Guidance on Best Practice Based on Current Research Evidence

- Thoughtfully designed and carefully executed randomized controlled trials have a critical role in establishing best practices.

- There are, however, few randomized controlled trials of psychological interventions following mass violence.

There is limited Level 1 evidence to definitively confirm or refute the effectiveness of any early psychological intervention following mass violence and disasters.

The current evidence, often drawing on other types of traumatic events, permits the following conclusions:

Some practices that may have captured public interest have not been proven effective, and *some may do harm.*

EMDR

There is **no credible evidence** that eye movement desensitization and reprocessing (EMDR) ***as an early mental health intervention***, following mass violence and disasters, is a treatment of choice over other approaches.

Debriefing

There is ***some*** Level 1 evidence suggesting that early intervention in the form of **a single one on-one recital of events and expression of emotions** evoked by a traumatic event (as advocated in **some forms** of psychological debriefing) **does not consistently reduce risks** of later developing PTSD or related adjustment difficulties.

Some survivors (e.g., those with high arousal) may be put ***at heightened risk for adverse outcomes*** as a result of such early interventions.

The term "debriefing" should be used only to describe operational debriefings

Although **operational debriefings** can be described as "early interventions," they are done primarily for reasons ***other than preventing or reducing mental disorders.***

There is some Level 1 evidence for the effectiveness of early, brief, and focused psychotherapeutic intervention (provided on an individual or a group basis) for reducing distress in bereaved spouses, parents, and children.

There is some Level 1 evidence that selected cognitive behavioral approaches (CBT) may help reduce incidence, duration, and severity of ASD, PTSD, and Depression in trauma survivors (e.g., victims of accidents, rape, and crime).

Note that these were individual victim events and it's a leap to jump to effectiveness post mass disaster.

Follow-Up
(for Whom and Over What Period of Time?)

- Follow-up should be offered to individuals and groups **at high risk of developing adjustment difficulties** following exposure to mass violence

- Resilience projects such as the FEMA funded Crisis Counseling programs and the associated outreach may be helpful in individual and community recovery, but the evidence is just now evolving.

Expertise, Skills, and Training for Providers of Early Intervention Services

•Individuals who provide early mental health interventions or consultations need to make appropriate referrals when additional expertise is needed.

•Certain interventions—mass education via media outlets, psychological triage leadership consultations, and interventions that rely on detailed recall of traumatic experiences—have a high potential for unintended harm.

•The leadership should select professionals who have the high degree of training, expertise, accountability and responsibility required to provide these interventions.

The Virginia Scene

A cooperative statewide and local approach to behavioral health services.

National Issues Translate into Local Issues

- Interagency politics/no clear agency responsibility
- Lack of resources/ allocation of resources
- Lack of interest
- Lack of plan/guidance to communities
- Overestimation of available resources
- Credentials and training standards

Key Operating Principles of Early Behavioral Health Intervention

- Planning
- Preparation
- Education/Training
- Service provision
- Evaluation

It is essential that these components be operationalized and used for service delivery, research, education, and consultation activities.

"Mass Violence", 2003 NIMH, DOD

TADBHAC
Terrorism and Disaster Behavioral Health Advisory Council

- Psychiatry
- Psychology
- DMHMRSAS (Public MH, Substance Abuse, Planning)
- CSB System (VACSB)
- VDH
- VDEM
- MHAV
- Universities (VCU, UVA)
- Red Cross

state level coordinating committee

Ensure that mental health is a portion of the evolving plan
-training needs and guidelines
-standards for credentialing
-methods and recommendations for coordinating inter-group/agency responses.

Collaboration of local MH/SA resources

Will vary from community to community

ex… CSB (s)

Western State Hospital

University -Psychiatry

-Psychology

-Student Health (CAPS)

Employee Assistance Program

Red Cross Disaster MH- local chapter

MH Association- local chapter

Chaplaincy/Clergy

Medical Reserve Corps

Emergency Manager for local govt.

TJHD Emergency Planner

Inventory of current MH resources in disaster response
-Med School?,University? Military? Fed Facility?

-Consensus on minimum training
-New training needs
-Minimize duplication -encourage reciprocity
-Volunteer and Staffer Credentialing

In the age of Bioterror, the need for **Credentialing and pre-assignment** of participating personnel will be paramount.

Local Goals and Objectives

- Train BH response groups in the ICS (NIMS)
- Work with existing BH emergency/crisis structure
- Develop acute mutual aid agreements between agencies in the event of disaster.
  -Red Cross as lead due to existing structure
- Set up preplanned call out list to agency designees
- Ensure common communication available
- Establish BH position in the EOC as advisor
- BH experts on LEPC
- Work with MRC/ARC to coordinate volunteers
- Working on writing the BH response into local plan
- Set up a common basic training/approach
- Data gathering and Epidemiology/Research

To infuse the prevention principles of **Mental Wellness and Risk Communication** into overall disaster response by participating as full partners in the process.

This is a clear lesson learned from the 9/11, Anthrax and Sniper responses in NYC and Northern Virginia.

Non-Local/Late Assistance

American Red Cross (ARC)

Disaster MH Services from other areas

Disaster Psychiatry Outreach (DPO)

Psychiatrists with training

Disaster Medical Assistance Teams (DMAT)

No DMAT team in Virginia

2 MH teams nationwide-CA, IL

QUESTIONS